


Exhibit J to Class Action Complaint

Adm: Narcop 09116

NaphCare

## Medical Emergency Code Report

Clinic 0920.

Facility: <u>FCT</u>	Date: <u>5/25/23</u>	Code: <u>?</u>	Time Called: <u>09:15</u>	Time Arrived: <u>09:17</u>
Name: <u>HANBRIK, Nikarag</u>		Location: <u>4N.</u>	ID#: _____	Allergies: _____
Reason Called: _____				
Vitals Upon Arrival: O2 SAT: _____ BP: _____ HR: _____ TEMP: _____ RESP: _____ BS: _____				
Witnesses: <u>offices Coleman, MA - MASON</u>				
Position of Patient Upon Arrival: <u>lying in floor face down</u>				
Officers Involved: <u>Coleman.</u>				
Health Care Staff Involved: Nurses: <u>MA: MASON</u> MD: _____ NP/PA: <u>MORAN</u>				
Chief Complaint: <u>Unresponsive</u>		Onset: <u>09:15</u>		
Medical History: <input type="checkbox"/> None <input type="checkbox"/> Asthma <input type="checkbox"/> CAD <input type="checkbox"/> COPD <input type="checkbox"/> CVA <input type="checkbox"/> DM <input type="checkbox"/> HTN <input type="checkbox"/> HIV <input type="checkbox"/> MI <input type="checkbox"/> Seizures <input type="checkbox"/> Cancer <input type="checkbox"/> Hep C <input type="checkbox"/> Other: _____				
Current Medications: _____				
Respiratory		CIRCLE ALL THAT APPLY		Cardiovascular
<input type="checkbox"/> WNL <input type="checkbox"/> Labored <input type="checkbox"/> Cough <input type="checkbox"/> SOB <input type="checkbox"/> Wheezes <input type="checkbox"/> Stridor <input type="checkbox"/> Crackles <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Pain with Breathing <input type="checkbox"/> Diminished <input type="checkbox"/> Nasal Flaring <input type="checkbox"/> Other: _____		<input type="checkbox"/> WNL <input type="checkbox"/> Chest Pain <input type="checkbox"/> Left Arm Pain <input type="checkbox"/> Diaphoresis <input type="checkbox"/> Orthopnea <input type="checkbox"/> Edema <input type="checkbox"/> Palpitations <input type="checkbox"/> Dizzy Spells <input type="checkbox"/> Syncope <input type="checkbox"/> Tachycardia <input type="checkbox"/> Bradycardia <input type="checkbox"/> Other: _____		<input type="checkbox"/> Non Verbal
Neurological		Treatments		
<input type="checkbox"/> WNL <input type="checkbox"/> Oriented x3 <input type="checkbox"/> Disoriented to person/place/time <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Seizure <input type="checkbox"/> Tremors <input type="checkbox"/> Fainting <input type="checkbox"/> Walking Problems <input type="checkbox"/> Speech Problems <u>None</u> R/L: Altered sensation: <u>Verbal</u> R/L: Altered motor: <u>None</u> Pulses: Present Absent Other: <u>unable to assess</u>		<input type="checkbox"/> Oxygen applied: Time _____ liters <input type="checkbox"/> IV access started: Time _____ Cath size _____ <input type="checkbox"/> Site _____ Inserted by _____ <input type="checkbox"/> IVF Started <input type="checkbox"/> Narcan/Naloxone administered <input type="checkbox"/> Glucose/Glucagon administered <input type="checkbox"/> CPR started: Time _____ <input type="checkbox"/> CPR terminated: Time _____ <input type="checkbox"/> Life Pack applied: Time _____ <input type="checkbox"/> VS every 5-10 minutes until transported: Time: _____ BP _____ Pulse _____ Resp _____ O2 Sats _____ Time: _____ BP _____ Pulse _____ Resp _____ O2 Sats _____ Time: _____ BP _____ Pulse _____ Resp _____ O2 Sats _____ <input type="checkbox"/> Emergency department notification time: _____ <input type="checkbox"/> Report given to: _____ <input type="checkbox"/> Time ambulance notified: _____ <input type="checkbox"/> Ambulance arrival time: _____ <input type="checkbox"/> Ambulance departure time: _____		
Progress Notes				
<u>Negative Physical Findings. Non Verbal.</u>				

HAMBURG NKGMDEN 0103991212307058

to back, torso: unable to fully examined

Name

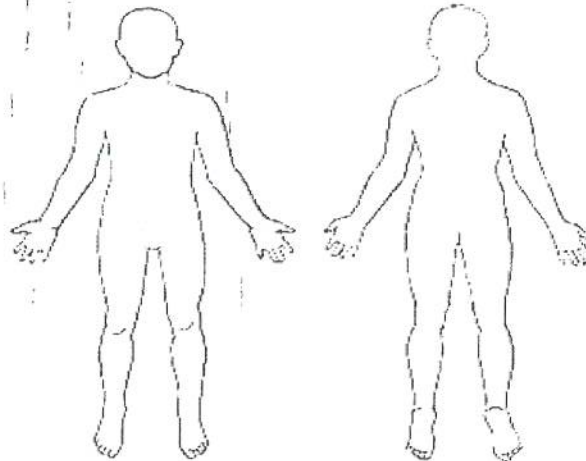
ID#

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## Medical Diagram of Injury

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_ 7. \_\_\_\_\_ 8. \_\_\_\_\_



FRONT

BACK

NOTIFY MEDICAL PROVIDER/RN IMMEDIATELY IF:

Lacerations	Fractures	Contusion
<input type="checkbox"/> Wound is severe/deep/requires sutures <input type="checkbox"/> Bleeding is uncontrolled <input type="checkbox"/> Wound has imbedded debris not easily irrigated <input type="checkbox"/> Laceration to the face, ear, nose, eyelid, or over joint <input type="checkbox"/> Wound that edges do not approximate easily with Steri-strips <input type="checkbox"/> Signs of infection present <input type="checkbox"/> Laceration to the Abdomen or chest that may penetrate underlying organs	<input type="checkbox"/> Obvious deformity, loss of sensation <input type="checkbox"/> Numbness/severe pain, absent distal pulses <input type="checkbox"/> Mechanism of injury suggested hidden trauma <input type="checkbox"/> Takes anticoagulants, over age 50 <input type="checkbox"/> X-rays, analgesics, tetanus booster, crutches	<input type="checkbox"/> Deformity is present <input type="checkbox"/> Impaired neurological/vascular status <input type="checkbox"/> Mechanism of injury suggesting hidden trauma <input type="checkbox"/> Marked swelling is present <input type="checkbox"/> Condition not responding to intervention

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Name	ID#	Outcome
Returned to Infirmary: <input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other: _____		
Out to Hospital: <input type="checkbox"/> Car <input type="checkbox"/> Ambulance <input type="checkbox"/> Other: _____		
Name/Credentials of Person Completing Report:		
Date/Time Report Completed:		

Report Submitted By: \_\_\_\_\_ Date: \_\_\_\_\_

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